NO. 48378-5

COURT OF APPEALS, DIVISION II
STATE OF WASHINGTON

DONNA ZINK, Appellant/Cross-Respondent

v.

PIERCE COUNTY, Respondent/Cross-Appellant

and

JOHN DOES, Respondents

Reply Brief of Cross-Appellant

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I. REPLY ARGUMENT

A. The Pierce County Sheriff is not a health care provider subject to RCW 70.02 for purposes of SSOSA records.

The PRA directs that it be liberally construed and its exemptions narrowly construed to protect the public's interests in disclosure. *Doe ex rel. Roe v. Washington State Patrol*, 185 Wn.2d 363, 371, 374 P.3d 63 (2016). While an "other statute" need not expressly address the PRA, it must expressly prohibit or exempt the release of records. *Id.* at 372. The "other statute" exemption in the PRA applies only to those exemptions explicitly identified in other statutes; its language does not allow a court 'to imply exemptions but only allows specific exemptions to stand'." *Id.*

The Washington State Supreme Court, in rejecting the assertion that RCW 4.24.550 should be construed as an "other" exemption statute to prohibit disclosure of convicted sex offender registration records, stated in *Doe* that "if the exemption is not found within the PRA itself, [the court] will find an 'other statute' exemption only when the legislature has made it explicitly clear that a specific record, or portions of it, is exempt or otherwise prohibited from production in response to a public records request." *Id.* at 373. "[W]hen a statute is not explicit, courts will not find an "other statute" exemption." *Id.* at 377 (citing *Belo Management Services, Inc. v. Click! Network*, 184 Wn.App. 649, 653–54, 343 P.3d 370

(2014). If a PRA exemption does exist, "[a]ll exceptions, including 'other statute' exceptions, are construed narrowly." *Fisher Broadcasting*, 180 Wn.2d 515, 525, 326 P.3d 688 (2014); RCW 42.56.030.

Where statutory language is clear and unambiguous, its meaning is determined from its language alone without consideration of legislative history. *C.J.C. v. Corp. of Catholic Bishop of Yakima*, 138 Wn.2d 699, 708, 985 P.2d 262, 267 (1999), *as amended* (Sept. 8, 1999) "[A]bsent an ambiguity in the words of a statute,[judicial] analysis begins and ends with the statute's plain language." *United States v. Boone*, 477 F. App'x 99, 100 (4th Cir. 2012). All words in a statute must be given effect, no term should be rendered meaningless or unnecessary. *Cornu-Labat v. Hosp. Dist. No. 2 Grant Cnty.*, 177 Wn.2d 221, 231, 298 P.3d 741 (2013). If the Legislature employs different terms in a statute, courts presume a different meaning for each term. *Koenig v. City of Des Moines*, 158 Wash. 2d 173, 182, 142 P.3d 162, 165 (2006). The legislature is presumed to know the statutory scheme. *Bishop v. City of Spokane*, 142 Wn.App. 165, 171, 173 P.3d 318 (2007). Related statutory provisions are interpreted in relation to each other and all provisions harmonized. *C.J.C.* at 708.

Where a statute specifically designates the things or classes of things upon which it operates, an inference arises in law that all things or classes of things omitted from it were intentionally omitted by the

Legislature under the maxim expressio unius est exclusio alterius—specific inclusions exclude implication. *State v. Roadhs*, 71 Wn.2d 705, 707, 430 P.2d 586 (1967); *Washington Nat. Gas Co. v. Pub. Util. Dist. No. 1 of Snohomish Cty.*, 77 Wn.2d 94, 98, 459 P.2d 633, 636 (1969); *West v. Thurston County*, 168 Wn.App. 162, 183-84, 275 P.3d 1200 (2012) (applying expressio unius est exclusio alterius to the PRA); *Algona v. Sharp*, 30 Wn.App. 837, 842–843, 638 P.2d 627 (1982) (where assessment liens were not listed among several other types of liens in a homestead statute, it must be inferred legislature intended their omission). By the same token, "[w]here a statute provides for a stated exception, no other exceptions will be assumed by implication." *Sulkosky v. Brisebois,* 49 Wn. App. 273, 277–78, 742 P.2d 193 (1987). Where the Legislature omits language from a statute, intentionally or inadvertently, the court will not read into the statute the language that it believes was omitted. *Manary v. Anderson*, 176 Wn.2d 342, 357, 292 P.3d 96 (2013) (noting that the admonition is particularly appropriate where "reading" non-existent language into a statute would otherwise conflict with a more general provision that is subject to liberal construction).

B. SSOSA evaluations held by the Pierce County sheriff are not exempt health care information under RCW 42.56.360(2).

Respondent John Does (hereinafter "Does") contend that SSOSA evaluations are exempt under RCW 42.56.360(2), which reads: "Chapter 70.02 RCW *applies* to public inspection and copying of health care information of patients." (emphasis added). By its plain terms, RCW 42.56.360(2) does not directly exempt or confer confidentiality upon any public record absent some other provision within RCW 70.02, the Uniform Health Care Information Act[1] (UHCIA). Stated otherwise, RCW 42.56.360(2) is not a "stand-alone" exemption that ends further inquiry. To determine if a public record is exempt, RCW 42.56.360(2) directs public agencies to review RCW 70.02 to determine if the agency is a covered entity under the UHCIA and whether the specific records are also deemed exempt under that act.[2]

For example, the UHCIA clearly applies to public agencies that qualify as a "health care facility" or "health care provider" as defined by RCW 70.02.010(15)[3] and (18)[4]. Examples of such agencies would include

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[1] See RCW 70.02.902, which proves: This act may be cited as the uniform health care information act.

[2] RCW 42.56.360(2) was an original provision of the Uniform Health Care Information Act as enacted in 1991 by the passage of S.H.B. 1828. (Appendix A). The text of RCW 42.56.360(2), found in section 902 of S.H.B.1828, was originally codified in former RCW 42.17.312, a stand-alone provision of the Public Disclosure Act (PDA). Significantly, the text of section 902 was not codified under former RCW 42.17.310, which was recognized as the primary exemption statute of the PDA.

[3] A "Health care facility" means a hospital, clinic, nursing home, laboratory, office, or similar place where a health care provider provides health care to patients. RCW 70.02.010(15)

[4] A "Health care provider" means a person who is licensed, certified, registered, or

public psychiatric hospitals (e.g., Western State Hospital), county-owned hospitals (e.g., Harborview Medical Center), public hospital districts established under RCW 70.44 (e.g. Quincy Valley Medical Center), and Department of Corrections medical units that provide health care to inmate patients. *See e.g., Oliver v. Harborview Medical Center*, 94 Wn.2d 559, 618 P.2d 76 (1980) (Harborview patient records are public records); *Cornu-Labat v. Hosp. Dis. No. 2 Grant County*, 177 Wn.2d 226, 298 P.3d 741 (2013) (Quincy Valley Medical Center, a public hospital district, is subject to the PRA); *Prison Legal News v. Department of Corrections,* 154 Wn.2d 628, 644, 115 P.3d 316 (2005) (records of medical misconduct by prison medical staff pertaining to inmate patients are public records). RCW 42.56.360(2) plainly indicates that such public agency "health care providers" would be required to treat a public records act request for "health care information of patients" pursuant to the disclosure terms of RCW 70.02.

The legislature has also made provision for RCW 70.02 to apply in certain instances to entities that are not "health care providers." In some instances the legislature has authorized health care providers to disclose health care information to third parties who are not health care providers

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otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession. RCW 70.02.010(18).

without placing any redisclosure limits or prohibitions upon them.

For example, RCW 70.02.200(1)(g) mandates that a health care provider disclose to law enforcement authorities any evidence of criminal conduct committed on the premises of a health care provider or health care facility without limitation on the law enforcement agency's ability to redisclose the information to a prosecutor or other party. Similarly, RCW 70.02.200(2)(b) mandates that a health care provider disclose a patient's identity, condition, and diagnosis to law enforcement if the patient is being treated for a gunshot or knife wound believed to be intentionally inflicted. That provision rationally imposes no redisclosure prohibition on law enforcement, permitting disclosure to a prosecutor or any other entity.

In other instances the Legislature explicitly prohibits third party nonhealth-care provider recipients of health care information from any further redisclosure of records. For example, under RCW 70.02.050(2)(a), the Department of Health is permitted to receive health care information of a patient for purposes of licensure proceedings, or for investigation of unprofessional provider conduct, but the Legislature provided that "[a]ny health care information obtained under this subsection is exempt from public inspection and copying pursuant to chapter 42.56 RCW[.]" By contrast, a county sheriff department would not find a similar provision in RCW 70.02 that addresses SSOSA evaluations possessed by the agency

for purposes of convicted sex offender risk classification and registration. Further, the Legislature's inclusion of a specific redisclosure prohibition directed at the Department of Health indicates that the Legislature knows how to restrict agencies from further dissemination of health care information when it intends that result. The omission of any provision in RCW 70.02 prohibiting the disclosure or redisclosure of SSOSA records in response to a request under RCW 42.56 or otherwise referring to them as "confidential" under that chapter must be viewed as purposeful.

In contrast to RCW 42.56.360(2), the legislature used different terms in RCW 42.56.360(1) that specifically exempt the production of specified health care information in the possession of certain public agencies in response to a PRA request. The plain text of RCW 42.56.360(1) does not require the subject agencies to further "apply" the terms of RCW 70.02 to determine whether or not records must be withheld.

C. SSOSA evaluations held by the Pierce County Sheriff are not exempt under RCW 70.02.230.

The only specific UHCIA provision cited to by Does in support of their position that the SSOSA evaluations are somehow exempt is RCW 70.02.230. Yet, Does fail to discuss how the terms of that statute apply to the records in this case. Considered review of that statute's plain text

demonstrates it has no application to SSOSA evaluations possessed by the Pierce County Sheriff's Department (PCSD) for use in sex offender risk classification, registration, and community notification.

RCW 70.02.230 regulates the disclosure of "information and records related to mental health services" which is defined in RCW 70.05.010(21) as follows:

> "Information and records related to mental health services" means a type of health care information that relates to all information and records, including mental health treatment records, compiled, obtained, or maintained in the course of providing services by a mental health service agency, as defined in this section. This may include documents of legal proceedings under chapter 71.05, 71.34, or 10.77 RCW, or somatic health care information. For health care information maintained by a hospital as defined in RCW 70.41.020 or a health care facility or health care provider that participates with a hospital in an organized health care arrangement defined under federal law, "information and records related to mental health services" is limited to information and records of services provided by a mental health professional or information and records of services created by a hospital-operated community mental health program as defined in *RCW 71.24.025(8). (emphasis supplied)

RCW 70.02.010(29) defines "mental health treatment records" as follows:

> "Mental health treatment records" include registration records, as defined in RCW 71.05.020, and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department, by behavioral health organizations and their staffs, and by treatment facilities. "Mental health treatment records" include mental health information contained in a medical bill including, but not limited to, mental health drugs, a mental health diagnosis, provider name, and dates of service stemming from a medical service. "Mental health treatment records" do not include notes or

> records maintained for personal use by a person providing treatment services for the department, behavioral health organizations, or a treatment facility if the notes or records are not available to others. (emphasis supplied).

RCW 70.02.010(28) defines a "mental health service agency" as follows:

> "Mental health service agency" means a public or private agency that provides services to persons with mental disorders as defined under RCW 71.05.020 or 71.34.020 and receives funding from public sources. This includes evaluation and treatment facilities as defined in RCW 71.34.020, community mental health service delivery systems, or community mental health programs, as defined in *RCW 71.24.025, and facilities conducting competency evaluations and restoration under chapter 10.77 RCW. (emphasis supplied).

By its plain terms, RCW 70.02.230 pertains to records "compiled, obtained, or maintained in the course of providing services by a mental health service agency." PCSD is not a "mental health services agency" and the trial court made no contrary finding. SSOSA evaluations retained by PCSD for sex offender risk classification and community notification duties under RCW 4.24.550 do not qualify as records "compiled, obtained, or maintained in the course of providing services by a mental health service agency." Again, no contrary finding was made by the trial court. Also of significance is the Legislature's inclusion within the RCW 70.02.010(28) definition of "information and records related to mental health services" that it "may include documents of legal proceedings under chapter 71.05, 71.34, or 10.77 RCW . . ." The Legislature omitted within

that definition any reference to documents of legal proceedings under chapter 9.94A.670. That omission must be considered intentional.

The overall structure of RCW 70.02.230 makes plain that the legislature does not intend to prohibit disclosure of SSOSA evaluations held by a county sheriff. RCW 70.02.230(2) authorizes mental health services agencies to make select disclosures of "information and records related to mental health services" to nonhealth-care providers. The Legislature has provided that in some instances recipient agencies are explicitly prohibited from any redisclosure of that information, but in other instances the Legislature has chosen to not impose a redisclosure prohibition. For example a law enforcement officer may requests that a mental health professional (MHP) investigate an individual for potential involuntary detention pursuant to RCW 71.05.150, and the MHP is permitted under RCW 70.02.230(e)(i) to later inform the officer in writing of the results of the investigation and whether it resulted in detention or release of the individual. The statute does not restrict the authority of the officer to redisclose that information for example in an investigative report or directly to a prosecutor for purposes of a criminal prosecution. Another example is RCW 70.02.230(2)(g), which permits a mental health service agency to disclose involuntary commitment records to a prosecutor to permit the prosecutor to fulfill responsibilities imposed under RCW

71.05.330(2), 71.05.340(1)(b), and RCW 71.05.335. Lastly, RCW 70.02.230(2)(m) permits a mental health services agency to disclose involuntary commitment records to both law enforcement officers and prosecutors to enforce RCW 9.41.040(2), which prohibits firearm possession by individuals who have been previously involuntarily committed for mental health treatment under RCW 71.05 and not had their right to possess a firearm restored under RCW 9.41.047. RCW 70.02.230(2)(m)(ii) specifically prohibits prosecutors and law enforcement officers from redisclosing that information to anyone other than the individual's defense attorney or to a jury or judge.

The redisclosure prohibition directed at a law enforcement agencies and prosecutors in RCW 70.02.230(2)(m)(ii) would be entirely unnecessary and superfluous if the legislature intended that those agencies be otherwise generally prohibited from disclosing the records under the general terms of RCW 70.02.230(1). Further, the legislature's specific inclusion of a provision prohibiting redisclosure of mental health records obtained for prosecution pursuant to RCW 70.02.230(m)(ii) should be interpreted to mean that the Legislature's specific omission of any such prohibition regarding SSOSA records in RCW 70.02.230 is intentional. RCW 70.02.230(2)(m)(ii) makes it clear that the legislature knows how to enact text that either limits or completely prohibits public agencies from

any further disclosure of the records *when it intends that result.*

The legislature is aware of the SSOSA statutory scheme and its provisions for providing courts, litigants and DOC personnel access to SSOSA evaluations and SSOSA treatment reports. Yet, RCW 70.02.230 nowhere references SSOSA evaluations or any other records pertaining to RCW 9.94A.670 proceedings. Does' assertion that RCW 70.02.230 should apply to SSOSA evaluations would lead to absurd results. SSOSA evaluations are considered in open court. The SRA's SSOSA procedure cannot be reconciled with a determination that SSOSA evaluations constitute "the fact of admission to a provider for mental health services" and "must be confidential." If Does' argument is accepted, a judgment and sentence order signed by a judge that imposed a SSOSA option and mandatory sex offender treatment pursuant to RCW 9.94A.670(5)(c) would in and of itself reveal "the fact of admission to a provider for mental health services" and thereby apparently violate RCW 70.02.230. Prosecutors and supervising DOC personnel are permitted to obtain SSOSA evaluations and as well as subsequent SSOSA treatment reports under RCW 9.94A.670. If a SSOSA is granted, sex offender treatment providers are mandated to disclose an offender's SSOSA treatment progress to prosecutors, supervising corrections officers, and courts on a quarterly basis over the course of a SSOSA sentence *without need of any*

court order. RCW 9.94A.670(8).[5] Similarly, Department of Health regulations mandate that sex offender treatment providers disclose additional information concerning an offender's progress in SSOSA treatment to prosecutors or corrections officers "when requested" and without need of any court order. See WAC 246-930-340(1)(c).[6] Additionally, RCW 9.94A.670 nowhere restricts prosecutors, a supervising community corrections officer, or a county sheriff or other law enforcement officer from redisclosing SSOSA evaluations or other SSOSA treatment progress records to the victim(s) of the offender, other investigating law enforcement personnel, or anyone else. See RCW 9.94A.670. Application of RCW 70.02.230(1) to SSOSA would completely conflict with the SSOSA suspended sentencing scheme.

The absence of any disclosure restrictions pertaining to SSOSA evaluations in either RCW 70.02.230 or RCW 9.94A.670 evince a clear

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[5] RCW 9.94A.670(8)(a) provides:
The sex offender treatment provider shall submit quarterly reports on the offender's progress in treatment to the court and the parties. The report shall reference the treatment plan and include at a minimum the following: Dates of attendance, offender's compliance with requirements, treatment activities, the offender's relative progress in treatment, and any other material specified by the court at sentencing. (emphasis added).

[6] (WAC) 246-930-340(1)(c) provides:
Quarterly progress reports documenting dates of attendance, treatment activities and duration, changes in the treatment plan, client compliance with requirements, and treatment progress shall be made in a timely manner to the court and parties. Providers shall provide additional information regarding treatment progress when requested by the court or a party. If there is more than one provider, the primary provider shall confer on all quarterly reports and provide one report to the required parties in a timely manner. (emphasis added).

legislative intent. The mandate of the Washington State Supreme Court articulated in *Doe ex rel. Roe v. Wash. State Patrol, supra*, compels the conclusion that no implied exemption should be construed where the statutes are uniformly silent. The trial court's order should be reversed.

The UHCIA prohibits disclosure of certain health care information by a health care provider, an individual who assists a health care provider in the delivery of health care, or an agent and employee of a health care provider." *Murphy v. State*, 115 Wash. App. 297, 314, 62 P.3d 533, 541–42 (2003), *cert. denied*, 541 U.S. 1087, 124 S.Ct. 2812, 159 L.Ed.2d 249 (2004). Does implicitly concede that the Pierce County Sheriff's Department (PCSD) is not "health care provider" as defined by RCW 70.02.010, and therefore not subject to the general disclosure restrictions that the Legislature has expressly imposed upon "health care providers" who maintain health care information pursuant to RCW 70.02.

D. The legislative findings in RCW 70.02.005(4) impose no duty upon nonhealth-care providers to exempt health care information.

Undaunted by the Legislature's decision to omit from RCW 70.02 any express provision that specifically exempts SSOSA evaluations retained by a county sheriff, Does contend that such an exemption should be judicially implied by resort to the general legislative findings of the UHCIA found in RCW 70.02.005(4). (Brief of Respondent at 17). The

specific finding relied upon by Does reads as follows:

> Persons other than health care providers obtain, use, and disclose health record information in many different contexts and for many different purposes. It is the public policy of this state that a patient's interest in the proper use and disclosure of the patient's health care information survives even when the information is held by persons other than health care providers.

RCW 70.02.005(4).

Legislative findings may be used as interpretive tool if ambiguity is found in a statute. *Payseno v. Kitsap County*, 186 Wn.App. 465, 471, 346 P.3d 784 (2015); *Yousouffian v. Office of Ron Sims*, 152 Wn.2d 421, 434, 98 P.3d 463 (2004). A statute is considered ambiguous when it can reasonably be interpreted in more than one way. *Fisher v. State ex rel. Dep't of Health*, 125 Wn. App. 869, 875, 106 P.3d 836, 838 *review denied*, 155 Wn.2d 1013 (2005) (holding state Attorney General's Office was not an entity subject to any health care disclosure restrictions imposed by the Uniform Health Care Information Act), *review denied*, 155 Wn.2d 1013 (2005). "But when the meaning of statutory language is plain, the statute is not ambiguous." *Id.*

Respondent Does nowhere identify any ambiguity within RCW 70.02 to warrant application of the findings of the UHCIA. If the court does consider RCW 70.02.005(4), it would be appropriate to consider the official commentary to the model act that sheds light on the intent of that finding. *See Suquamish Tribe v. Central Puget Sound growth*

Management Hrgs. Bd., 156 Wn.App. 743, 776, 235 P.3d 812 (2010); *Townsend v. Quadrant Corp.*, 153 Wn.App. 870, 878, 224 P.3d 818 (2009), *affirmed*, 73 Wn.2d 451, 268 p.3d 917 (2012)

Section 1-101(4) of the model UHCIA, codified in RCW 70.02.005(4), contains an official commentary directly refuting Does' assertion that the finding should be interpreted as a basis to exempt health care information held by third party nonhealth-care providers. The official commentary states in relevant part:

> The fourth statement makes the point that many nonhealth-care providers obtain, use, and disclose health care information for innumerable nonhealth-care purposes. It is the public policy of the state that a patient has an interest in the proper use and disclosure of the patient's health care information even when the information is held by non-health-care providers. *The purpose of this statement is to recognize that such rights exist as a matter of case law and other expressions of public policy and to assure that enactment of the Act--notwithstanding its general limitation to health-care provider--does not undercut health-record privacy rights that may exist under other law and in other contexts.*
>
> *There are two reasons why the Act does not attempt to regulate the use or redisclosure of health-care information once such information is held by nonhealth-care providers* (except in those limited circumstances set forth in Article II where a health-care provider makes health-care information available to third parties without the patient's consent and in order to meet the provider's needs or interests). *First, the expectations that a patient and society can rightfully have concerning the use and disclosure of health-care information must necessarily change when health care information is held by nonhealth-care providers.* The type of relationship that nonhealth-care providers have with patients is inevitably different that the relationship that health-care providers have with patients, The interests that will be advanced or deterred

> by confidentiality are different; the needs of the nonhealth-care providers to use and disclose the information are different; and the threat to patient privacy interests is different. These issues are complex, and require different responses, depending on the identity of the particular holder of the record and the reasons for which the records are held.

Uniform Laws Annotated, Matrimonial, Family and Health Laws, Master Ed., Vol. 9, Part I, p. 480 (1988) (emphasis supplied) (Appendix B).

The official commentary plainly indicates RCW 70.02.005(4) is not intended as authority to exempt health care information maintained by nonhealth-care providers, and emphasizes that a legislature must otherwise enact such third party disclosure restrictions if it intends such results.

Further, if the court accepts Does' argument that RCW 70.02.005(4) should be interpreted as a "stand alone" provision that exempts a SSOSA evaluation or health care information held by a third party not otherwise covered under RCW 70.02, it will lead to significant unintended consequences. First, such a statutory construction would render more specific exemptions enacted by the legislature, such as RCW 70.02.050(2)(a), RCW 70.02.230(2)(m)(ii), and RCW 42.56.360(1) and 42.56.360(3) entirely superfluous. Secondly, use of RCW 70.02.005(4) as a basis to imply an exemption would not be limited to SSOSA evaluations held by a county sheriff. The plain text of RCW 70.02.005(4), which refers to "persons other than health care providers," would be applicable

to all "persons" who possess health care information, both public and private as that term is defined in RCW 70.02.010(33). Such a decision would have far reaching future consequences unintended by the Legislature.

Consistent with the official commentary to the model UHCIA, the Legislature has not relied upon RCW 70.02.005(4) as an exemption directed at third parties, but has instead enacted specific provisions when it intended that certain public agencies be prohibited from re-disclosure of health care information received from a health care provider. *See e.g.,* RCW 70.02.050(2)(a) (prohibiting Department of Health from PRA disclosure of health care information obtained to investigate unprofessional conduct); RCW 70.02.230(2)(m)(ii) (prohibiting prosecutors and law enforcement from redisclosing health care records beyond criminal defense attorneys and trial courts); RCW 42.56.360(4) (exempting maternal mortality review board records held by Department of Health).

Appellate courts have also consistently declined to resort to the findings in RCW 70.02.005(4) as a basis to impose health care information disclosure duties of RCW 70.02 upon entities public or private that are not otherwise expressly designated as entities subject to the UHCIA. *See Murphy v. State*, 115 Wn.App. 297, 62 P.3d 533 (2003)

(ruling that as a general statement of legislative intent, RCW 70.02.005(4) creates no enforceable disclosure duties upon the state pharmacy board, a nonhealth-care provider), *cert. denied,* 541 U.S. 1087, 124. S.Ct. 2812, 159L.Ed.2d 249 (2004); *Fisher v. State ex rel. Dep't of Health*, 125 Wn.App. 869, 878, 106 P.3d 836 (2005) (holding patient had no HCIA cause of action against state attorney general or Department of Health as neither was a health care provider or health care facility); *see also* 1997 Op. Att'y Gen. No. 2 (advising Secretary of State that for purpose of a Public Disclosure Act, Department of Health was not a "health care provider" subject to the disclosure restrictions of UHCIA concerning diet records). The Legislature's decision to not amend Chapter 70.02 RCW in response to the Court of Appeals' opinion in *Murphy v. State, supra,* should be viewed as supportive of that court's interpretation of RCW 70.02.005(4).

After filing their response brief, Does submitted a statement of additional authority citing to Division One's recent opinion in *John Doe G v. Department of Corrections*, 197 Wn.App. 609, 391 P.3d 496 (2017). That opinion addressed a PRA request that Ms. Zink submitted to the DOC in 2014 seeking all SSOSA evaluations held by that agency since 1990. *Id.* A class of "John Doe" sex offenders sued to prevent release of the record and the trial court enjoined the release of level I sex offenders.

Id. Both Zink and the DOC appealed the trial court's ruling. Division One affirmed the trial court order enjoining disclosure of level I offender SSSOSA evaluations. *Id.* The facts of the present case are distinguishable from that of *John Doe G* because the records are held by different agencies. Further, the reasoning in *John Doe G* is troubling because it appears the court did not correctly apply RCW 42.56.360(2) and RCW 70.02. Instead, Division One concluded in a footnote, and without any statutory analysis that, "Although RCW 70.02.020(1) applies only to "a health care provider, an individual who assists a health care provider in the delivery of health care, or an agent and employee of a health care provider"—categories that likely would not include the Department—RCW 42.56.360(2) incorporates RCW 70.02.020 into the PRA and thus restricts disclosures by the Department. *John Doe G v. Dep't of Corr.*, 197 Wn. App. 609, 391 P.3d 496, 501 (2017). Division One then merely cited to *Prison Legal News*, 154 Wn.2d at 644, 115 P.3d 316 (2005), without discussion of the distinguishing facts at issue in *Prison Legal News.*

In *Prison Legal News*, DOC responded to an inmate public record request that sought patient medical records of inmates. The request submitted to DOC sought: "documents of all disciplinary actions against DOC medical providers by any licensing authority; (2) names of all doctors, nurses, physician assistants, and mental health providers DOC

employed; (3) records related to DOC medical staff practicing with restricted or suspended licenses; (4) records of prisoner deaths in 1999; (5) records of prisoner deaths where medical negligence was a factor; (6) postmortem documents regarding prisoner deaths; and (7) records of staff and prisoner assaults requiring medical treatment from 1994 through 1999." *Prison Legal News*, 154 Wn.2d at 632. It was never in dispute in *Prison Legal News* that the records sought were those of DOC patients who received medical care from DOC medical personnel. In other words, it was undisputed by the parties that the records sought were "health care information" created by "healthcare providers" and that the DOC medical facility was a "health care facility." After receiving the request, DOC redacted all references to medical information, including all patient identifiers and medical conditions, citing to RCW 70.02.020 as incorporated through former RCW 42.17.312. *Id.* at 644. The Supreme Court accepted application of RCW 70.02 to the inmate medical records held by DOC in its capacity as a medical provider under RCW 70.02. *Id.* The status of those records as "health care information" under RCW 70.02 was not disputed by DOC or the requester. However, while the court accepted that DOC's redaction of patient identifiers was proper, the court rejected DOC's additional redaction of all health care information because it violated the PRA's mandate of narrow redaction:

> [T]he broad mandate favoring disclosure under the [PRA] requires the agency demonstrate that each patient's health care information is "readily associated" with that patient in order to withhold the health care information under RCW 70.02.010(6). Where there is a dispute over whether health care information is readily identifiable with a specific patient even when the patient's identity is not disclosed, the trial court can use in camera review should it need to examine unredacted records to make its independent determination.

Id. at 645-46 (internal citation omitted).

Division One's opinion in *John Doe G* is fundamentally flawed because it fails to apply RCW 70.02 with the acknowledgement that DOC does not hold SSOSA evaluations in the capacity of a "health care provider." DOC obtains and uses SSOSA evaluations pursuant to its duties to supervise convicted offenders and assign risk level classifications. See RCW 9.94A.670; RCW 9.94A.501(4)(f)(requiring supervision of SSOSA offenders). Unlike the DOC staff in *Prison Legal News*, the DOC corrections officers that use SSOSA records are not medical personnel nor are they providing any health care to the SSOSA sex offenders. The DOC personnel holding SSOSA evaluations in *John Doe G* are not acting as "health care providers." Further, DOC community corrections personnel generally do not obtain SSOSA evaluations from a sex offender treatment provider or the author of the SSOSA evaluation, but typically the "prosecutor or defense attorney usually provides the evaluation to the community corrections officer

investigating the offender's history." *John Doe G,* 391 P.3d at 500. The Legislature has made it clear that RCW 70.02 only applies to health care providers unless there is a specific additional text restricting health care information that a "health care provider" has directly disclosed to a nonhealth-care provider. RCW 70.02 makes it plain that the status of the a third party record holder, and the specific purpose for which they obtain health care information is critical to a proper application of any restrictions imposed under RCW 70.02. Division One failed to apply those provisions. No provision in RCW 70.02 restricts disclosure of SSOSA evaluations held by a DOC community corrections officer acting as a supervisor of sex offenders pursuant to RCW 9.94A.670.

Equally significant is the fact that DOC does not obtain SSOSA evaluations from health care treatment providers, but instead receives them from either a prosecutor of the offender's criminal defense attorney.[7] *See John Doe G*, 391 P.3d at 500. RCW 70.02 nowhere regulates the disclosure of "health care information" that is obtained by a nonhealth-care provider, such as DOC, from another nonhealth-care provider, such as a prosecutor or criminal defense attorney. Lastly, *John Doe G* failed to

[7] The record of any particular SSOSA proceeding is not before this court. Nonetheless, it defies reason to conclude that a voluntary disclosure of a SSOSA evaluation by a defense attorney to a DOC employee is anything other than a waiver as to any claim under RCW 70.02.

clearly apply the Supreme Court's directive in *Prison Legal News* that if a record does qualify as "health care information," the agency may only redact patient identifiers and otherwise disclose the remainder of the record, including any "health care information" not readily associated with the patient. *See Prison Legal News*, at 645-48 ("on remand DOC must prove that each patient's health care information would be readily identifiable with that patient even if that patient's identity isn't known[.]" Instead, Division One noted that DOC had indicated in its briefing that in addition to victim names, it "would redact information that "clearly qualifie[s] as medical information." *John Doe G*, 391 P.3d at 503. The Court then merely affirmed the trial court's ruling, which exempted the records in their entirety. *Id. John Doe G* failed to acknowledge that if the records are "health care information" only the patient names can be redacted under the mandate of *Prison Legal News*, not the health care information, if any exists. It is Pierce County's understanding that both DOC and Ms. Zink are petition for discretionary review of this decision and it appears that there are significant grounds to grant review. Regardless of that outcome, the reasoning of *John Doe G* is manifestly flawed and should not be relied upon because it regrettably fails to correctly apply the Legislature's scheme in the UHCIA and the Supreme Court's decision in *Prison Legal News*.

II. CONCLUSION

Trial court erred in ruling that RCW 70.02 exempts SSOSA evaluations held by the Pierce County Sheriff's Department. Respondents have not established that RCW 70.02 exempts SSOSA evaluations. The trial court should be reversed and the injunction should be dissolved.

DATED this 26th day of April, 2017.

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Reply Brief of Cross-Appellant was electronically filed and delivered this 26th day of April, 2017, by electronic mail pursuant to the agreement of parties as follows:

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NO. 48378-5

COURT OF APPEALS, DIVISION II
STATE OF WASHINGTON

DONNA ZINK, Appellant/Cross-Respondent

v.

PIERCE COUNTY, Respondent/Cross-Appellant

and

JOHN DOES, Respondents

APPENDIX

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CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1828

Chapter 335, Laws of 1991

52nd Legislature
1991 Regular Session

UNIFORM HEALTH CARE INFORMATION ACT

EFFECTIVE DATE: 7/28/91

Passed by the House March 19, 1991
Yeas 98 Nays 0

JOE KING
Speaker of the House of Representatives

Passed by the Senate April 18, 1991
Yeas 43 Nays 2

JOEL PRITCHARD
President of the Senate

Approved May 21, 1991

BOOTH GARDNER
Governor of the State of Washington

CERTIFICATE

I, Alan Thompson, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1828** as passed by the House of Representatives and the Senate on the dates hereon set forth.

ALAN THOMPSON
Chief Clerk

FILED

May 21, 1991 - 11:00 a.m.

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1828

AS AMENDED BY THE SENATE

Passed Legislature - 1991 Regular Session

State of Washington 52nd Legislature 1991 Regular Session

By House Committee on Health Care (originally sponsored by Representative Appelwick).

Read first time March 6, 1991.

AN ACT Relating to the uniform health care information act; adding a new section to chapter 42.17 RCW; adding a new chapter to Title 70 RCW; creating new sections; and prescribing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

ARTICLE I

FINDINGS AND DEFINITIONS

NEW SECTION. **Sec. 101.** LEGISLATIVE FINDINGS. The legislature finds that:

(1) Health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy, health care, or other interests.

(2) Patients need access to their own health care information as a matter of fairness to enable them to make informed decisions about

their health care and correct inaccurate or incomplete information about themselves.

(3) In order to retain the full trust and confidence of patients, health care providers have an interest in assuring that health care information is not improperly disclosed and in having clear and certain rules for the disclosure of health care information.

(4) Persons other than health care providers obtain, use, and disclose health record information in many different contexts and for many different purposes. It is the public policy of this state that a patient's interest in the proper use and disclosure of the patient's health care information survives even when the information is held by persons other than health care providers.

(5) The movement of patients and their health care information across state lines, access to and exchange of health care information from automated data banks, and the emergence of multistate health care providers creates a compelling need for uniform law, rules, and procedures governing the use and disclosure of health care information.

NEW SECTION. **Sec. 102.** DEFINITIONS. As used in this chapter, unless the context otherwise requires:

(1) "Audit" means an assessment, evaluation, determination, or investigation of a health care provider by a person not employed by or affiliated with the provider to determine compliance with:

(a) Statutory, regulatory, fiscal, medical, or scientific standards;

(b) A private or public program of payments to a health care provider; or

(c) Requirements for licensing, accreditation, or certification.

(2) "Directory information" means information disclosing the presence and the general health condition of a particular patient who

is a patient in a health care facility or who is currently receiving emergency health care in a health care facility.

(3) "General health condition" means the patient's health status described in terms of "critical," "poor," "fair," "good," "excellent," or terms denoting similar conditions.

(4) "Health care" means any care, service, or procedure provided by a health care provider:

(a) To diagnose, treat, or maintain a patient's physical or mental condition; or

(b) That affects the structure or any function of the human body.

(5) "Health care facility" means a hospital, clinic, nursing home, laboratory, office, or similar place where a health care provider provides health care to patients.

(6) "Health care information" means any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care. The term includes any record of disclosures of health care information.

(7) "Health care provider" means a person who is licensed, certified, registered, or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession.

(8) "Institutional review board" means any board, committee, or other group formally designated by an institution, or authorized under federal or state law, to review, approve the initiation of, or conduct periodic review of research programs to assure the protection of the rights and welfare of human research subjects.

(9) "Maintain," as related to health care information, means to hold, possess, preserve, retain, store, or control that information.

(10) "Patient" means an individual who receives or has received health care. The term includes a deceased individual who has received health care.

(11) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(12) "Reasonable fee" means the charges for duplicating or searching the record specified in RCW 36.18.020 (8) or (16), respectively. However, where editing of records by a health care provider is required by statute and is done by the provider personally, the fee may be the usual and customary charge for a basic office visit.

ARTICLE II

DISCLOSURE OF HEALTH CARE INFORMATION

NEW SECTION. **Sec. 201.** DISCLOSURE BY HEALTH CARE PROVIDER. Except as authorized in section 204 of this act, a health care provider, an individual who assists a health care provider in the delivery of health care, or an agent and employee of a health care provider may not disclose health care information about a patient to any other person without the patient's written authorization. A disclosure made under a patient's written authorization must conform to the authorization.

Health care providers or facilities shall chart all disclosures, except to third-party health care payors, of health care information, such chartings to become part of the health care information.

NEW SECTION. **Sec. 202.** PATIENT AUTHORIZATION TO HEALTH CARE PROVIDER FOR DISCLOSURE. (1) A patient may authorize a health care

provider to disclose the patient's health care information. A health care provider shall honor an authorization and, if requested, provide a copy of the recorded health care information unless the health care provider denies the patient access to health care information under section 302 of this act.

(2) A health care provider may charge a reasonable fee, not to exceed the health care provider's actual cost for providing the health care information, and is not required to honor an authorization until the fee is paid.

(3) To be valid, a disclosure authorization to a health care provider shall:

(a) Be in writing, dated, and signed by the patient;

(b) Identify the nature of the information to be disclosed;

(c) Identify the name, address, and institutional affiliation of the person to whom the information is to be disclosed;

(d) Identify the provider who is to make the disclosure; and

(e) Identify the patient.

(4) Except as provided by this chapter, the signing of an authorization by a patient is not a waiver of any rights a patient has under other statutes, the rules of evidence, or common law.

(5) A health care provider shall retain each authorization or revocation in conjunction with any health care information from which disclosures are made. This requirement shall not apply to disclosures to third-party health care payors.

(6) Except for authorizations to provide information to third-party health care payors, an authorization may not permit the release of health care information relating to future health care that the patient receives more than ninety days after the authorization was signed. Patients shall be advised of the period of validity of their authorization on the disclosure authorization form.

(7) Except for authorizations to provide information to third-party health payors, an authorization in effect on the effective date of this section remains valid for six months after the effective date of this section unless an earlier date is specified or it is revoked under section 203 of this act. Health care information disclosed under such an authorization is otherwise subject to this chapter. An authorization written after the effective date of this section becomes invalid after the expiration date contained in the authorization, which may not exceed ninety days. If the authorization does not contain an expiration date, it expires ninety days after it is signed.

NEW SECTION. **Sec. 203.** PATIENT'S REVOCATION OF AUTHORIZATION FOR DISCLOSURE. A patient may revoke in writing a disclosure authorization to a health care provider at any time unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. A patient may not maintain an action against the health care provider for disclosures made in good-faith reliance on an authorization if the health care provider had no actual notice of the revocation of the authorization.

NEW SECTION. **Sec. 204.** DISCLOSURE WITHOUT PATIENT'S AUTHORIZATION. (1) A health care provider may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

(a) To a person who the provider reasonably believes is providing health care to the patient;

(b) To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to

the health care provider; or for assisting the health care provider in the delivery of health care and the health care provider reasonably believes that the person:

(i) Will not use or disclose the health care information for any other purpose; and

(ii) Will take appropriate steps to protect the health care information;

(c) To any other health care provider reasonably believed to have previously provided health care to the patient, to the extent necessary to provide health care to the patient, unless the patient has instructed the health care provider in writing not to make the disclosure;

(d) To any person if the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider to so disclose;

(e) Oral, and made to immediate family members of the patient, or any other individual with whom the patient is known to have a close personal relationship, if made in accordance with good medical or other professional practice, unless the patient has instructed the health care provider in writing not to make the disclosure;

(f) To a health care provider who is the successor in interest to the health care provider maintaining the health care information;

(g) For use in a research project that an institutional review board has determined:

(i) Is of sufficient importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;

(ii) Is impracticable without the use or disclosure of the health care information in individually identifiable form;

(iii) Contains reasonable safeguards to protect the information from redisclosure;

(iv) Contains reasonable safeguards to protect against identifying, directly or indirectly, any patient in any report of the research project; and

(v) Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project;

(h) To a person who obtains information for purposes of an audit, if that person agrees in writing to:

(i) Remove or destroy, at the earliest opportunity consistent with the purpose of the audit, information that would enable the patient to be identified; and

(ii) Not to disclose the information further, except to accomplish the audit or report unlawful or improper conduct involving fraud in payment for health care by a health care provider or patient, or other unlawful conduct by the health care provider;

(i) To an official of a penal or other custodial institution in which the patient is detained;

(j) To provide directory information, unless the patient has instructed the health care provider not to make the disclosure.

(2) A health care provider shall disclose health care information about a patient without the patient's authorization if the disclosure is:

(a) To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or

federal licensure, certification or registration rules or laws; or when needed to protect the public health;

(b) To federal, state, or local law enforcement authorities to the extent the health care provider is required by law;

(c) Pursuant to compulsory process in accordance with section 205 of this act.

(3) All state or local agencies obtaining patient health care information pursuant to this section shall adopt rules establishing their record acquisition, retention, and security policies that are consistent with this chapter.

NEW SECTION. **Sec. 205.** COMPULSORY PROCESS. (1) Before service of a discovery request or compulsory process on a health care provider for health care information, an attorney shall provide advance notice to the health care provider and the patient or the patient's attorney involved through service of process or first class mail, indicating the health care provider from whom the information is sought, what health care information is sought, and the date by which a protective order must be obtained to prevent the health care provider from complying. Such date shall give the patient and the health care provider adequate time to seek a protective order, but in no event be less than fourteen days since the date of service or delivery to the patient and the health care provider of the foregoing. Thereafter the request for discovery or compulsory process shall be served on the health care provider.

(2) Without the written consent of the patient, the health care provider may not disclose the health care information sought under subsection (1) of this section if the requestor has not complied with the requirements of subsection (1) of this section. In the absence of a protective order issued by a court of competent jurisdiction

forbidding compliance, the health care provider shall disclose the information in accordance with this chapter. In the case of compliance, the request for discovery or compulsory process shall be made a part of the patient record.

(3) Production of health care information under this section, in and of itself, does not constitute a waiver of any privilege, objection, or defense existing under other law or rule of evidence or procedure.

NEW SECTION. **Sec. 206.** CERTIFICATION OF RECORD. Upon the request of the person requesting the record, the health care provider or facility shall certify the record furnished and may charge for such certification in accordance with RCW 36.18.020(9). No record need be certified until the fee is paid. The certification shall be affixed to the record and disclose:

(1) The identity of the patient;

(2) The kind of health care information involved;

(3) The identity of the person to whom the information is being furnished;

(4) The identity of the health care provider or facility furnishing the information;

(5) The number of pages of the health care information;

(6) The date on which the health care information is furnished; and

(7) That the certification is to fulfill and meet the requirements of this section.

ARTICLE III

EXAMINATION AND COPYING OF RECORD

NEW SECTION. **Sec. 301.** REQUIREMENTS AND PROCEDURES FOR PATIENT'S EXAMINATION AND COPYING. (1) Upon receipt of a written request from a patient to examine or copy all or part of the patient's recorded health care information, a health care provider, as promptly as required under the circumstances, but no later than fifteen working days after receiving the request shall:

(a) Make the information available for examination during regular business hours and provide a copy, if requested, to the patient;

(b) Inform the patient if the information does not exist or cannot be found;

(c) If the health care provider does not maintain a record of the information, inform the patient and provide the name and address, if known, of the health care provider who maintains the record;

(d) If the information is in use or unusual circumstances have delayed handling the request, inform the patient and specify in writing the reasons for the delay and the earliest date, not later than twenty-one working days after receiving the request, when the information will be available for examination or copying or when the request will be otherwise disposed of; or

(e) Deny the request, in whole or in part, under section 302 of this act and inform the patient.

(2) Upon request, the health care provider shall provide an explanation of any code or abbreviation used in the health care information. If a record of the particular health care information requested is not maintained by the health care provider in the requested form, the health care provider is not required to create a new record or reformulate an existing record to make the health care information available in the requested form. The health care provider may charge a reasonable fee, not to exceed the health care provider's

actual cost, for providing the health care information and is not required to permit examination or copying until the fee is paid.

NEW SECTION. **Sec. 302.** DENIAL OF EXAMINATION AND COPYING. (1) Subject to any conflicting requirement in the public disclosure act, chapter 42.17 RCW, a health care provider may deny access to health care information by a patient if the health care provider reasonably concludes that:

(a) Knowledge of the health care information would be injurious to the health of the patient;

(b) Knowledge of the health care information could reasonably be expected to lead to the patient's identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate;

(c) Knowledge of the health care information could reasonably be expected to cause danger to the life or safety of any individual;

(d) The health care information was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes; or

(e) Access to the health care information is otherwise prohibited by law.

(2) If a health care provider denies a request for examination and copying under this section, the provider, to the extent possible, shall segregate health care information for which access has been denied under subsection (1) of this section from information for which access cannot be denied and permit the patient to examine or copy the disclosable information.

(3) If a health care provider denies a patient's request for examination and copying, in whole or in part, under subsection (1) (a) or (c) of this section, the provider shall permit examination and

copying of the record by another health care provider, selected by the patient, who is licensed, certified, registered, or otherwise authorized under the laws of this state to treat the patient for the same condition as the health care provider denying the request. The health care provider denying the request shall inform the patient of the patient's right to select another health care provider under this subsection. The patient shall be responsible for arranging for compensation of the other health care provider so selected.

"ARTICLE IV

CORRECTION AND AMENDMENT OF RECORD"

NEW SECTION. **Sec. 401.** REQUEST FOR CORRECTION OR AMENDMENT. (1) For purposes of accuracy or completeness, a patient may request in writing that a health care provider correct or amend its record of the patient's health care information to which a patient has access under section 301 of this act.

(2) As promptly as required under the circumstances, but no later than ten days after receiving a request from a patient to correct or amend its record of the patient's health care information, the health care provider shall:

(a) Make the requested correction or amendment and inform the patient of the action;

(b) Inform the patient if the record no longer exists or cannot be found;

(c) If the health care provider does not maintain the record, inform the patient and provide the patient with the name and address, if known, of the person who maintains the record;

(d) If the record is in use or unusual circumstances have delayed the handling of the correction or amendment request, inform the patient

and specify in writing, the earliest date, not later than twenty-one days after receiving the request, when the correction or amendment will be made or when the request will otherwise be disposed of; or

(e) Inform the patient in writing of the provider's refusal to correct or amend the record as requested and the patient's right to add a statement of disagreement.

NEW SECTION. **Sec. 402.** PROCEDURE FOR ADDING CORRECTION OR AMENDMENT OR STATEMENT OF DISAGREEMENT. (1) In making a correction or amendment, the health care provider shall:

(a) Add the amending information as a part of the health record; and

(b) Mark the challenged entries as corrected or amended entries and indicate the place in the record where the corrected or amended information is located, in a manner practicable under the circumstances.

(2) If the health care provider maintaining the record of the patient's health care information refuses to make the patient's proposed correction or amendment, the provider shall:

(a) Permit the patient to file as a part of the record of the patient's health care information a concise statement of the correction or amendment requested and the reasons therefor; and

(b) Mark the challenged entry to indicate that the patient claims the entry is inaccurate or incomplete and indicate the place in the record where the statement of disagreement is located, in a manner practicable under the circumstances.

ARTICLE V

NOTICE OF INFORMATION PRACTICES

NEW SECTION. **Sec. 501.** CONTENT AND DISSEMINATION OF NOTICE. (1) A health care provider who provides health care at a health care facility that the provider operates and who maintains a record of a patient's health care information shall create a "notice of information practices" that contains substantially the following:

NOTICE

"We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at ....."

(2) The health care provider shall place a copy of the notice of information practices in a conspicuous place in the health care facility, on a consent form or with a billing or other notice provided to the patient.

ARTICLE VI

PERSONS AUTHORIZED TO ACT FOR PATIENT

NEW SECTION. **Sec. 601.** HEALTH CARE REPRESENTATIVES. (1) A person authorized to consent to health care for another may exercise the rights of that person under this chapter to the extent necessary to effectuate the terms or purposes of the grant of authority. If the patient is a minor and is authorized to consent to health care without parental consent under federal and state law, only the minor may exercise the rights of a patient under this chapter as to information pertaining to health care to which the minor lawfully consented. In

cases where parental consent is required, a health care provider may rely, without incurring any civil or criminal liability for such reliance, on the representation of a parent that he or she is authorized to consent to health care for the minor patient regardless of whether:

(a) The parents are married, unmarried, or separated at the time of the representation;

(b) The consenting parent is, or is not, a custodial parent of the minor;

(c) The giving of consent by a parent is, or is not, full performance of any agreement between the parents, or of any order or decree in any action entered pursuant to chapter 26.09 RCW.

(2) A person authorized to act for a patient shall act in good faith to represent the best interests of the patient.

NEW SECTION. **Sec. 602.** REPRESENTATIVE OF DECEASED PATIENT. A personal representative of a deceased patient may exercise all of the deceased patient's rights under this chapter. If there is no personal representative, or upon discharge of the personal representative, a deceased patient's rights under this chapter may be exercised by persons who would have been authorized to make health care decisions for the deceased patient when the patient was living under RCW 7.70.065.

ARTICLE VII

SECURITY SAFEGUARDS AND RECORD RETENTION

NEW SECTION. **Sec. 701.** DUTY TO ADOPT SECURITY SAFEGUARDS. A health care provider shall effect reasonable safeguards for the security of all health care information it maintains.

NEW SECTION. **Sec. 702.** RETENTION OF RECORD. A health care provider shall maintain a record of existing health care information for at least one year following receipt of an authorization to disclose that health care information under section 203 of this act, and during the pendency of a request for examination and copying under section 301 of this act or a request for correction or amendment under section 401 of this act.

ARTICLE VIII

CIVIL REMEDIES

NEW SECTION. **Sec. 801.** CIVIL REMEDIES. (1) A person who has complied with this chapter may maintain an action for the relief provided in this section against a health care provider or facility who has not complied with this chapter.

(2) The court may order the health care provider or other person to comply with this chapter. Such relief may include actual damages, but shall not include consequential or incidental damages. The court shall award reasonable attorneys' fees and all other expenses reasonably incurred to the prevailing party.

(3) Any action under this chapter is barred unless the action is commenced within two years after the cause of action is discovered.

(4) A violation of this act shall not be deemed a violation of the consumer protection act, chapter 19.86 RCW.

ARTICLE IX

MISCELLANEOUS PROVISIONS

NEW SECTION. **Sec. 901.** CONFLICTING LAWS. (1) This chapter does not restrict a health care provider from complying with obligations

imposed by federal or state health care payment programs or federal or state law.

(2) This chapter does not modify the terms and conditions of disclosure under Title 51 RCW and chapters 13.50, 26.09, 70.24, 70.39, 70.96A, 71.05, and 71.34 RCW and rules adopted under these provisions.

NEW SECTION. **Sec. 902.** A new section is added to chapter 42.17 RCW to read as follows:

FREEDOM OF INFORMATION ACT. Chapter 70.-- RCW (sections 101 through 901 of this act) applies to public inspection and copying of health care information of patients.

NEW SECTION. **Sec. 903.** UNIFORMITY OF APPLICATION AND CONSTRUCTION. This act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this act among states enacting it.

NEW SECTION. **Sec. 904.** SHORT TITLE. This act may be cited as the uniform health care information act.

NEW SECTION. **Sec. 905.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 906.** CAPTIONS. As used in this act, captions constitute no part of the law.

NEW SECTION. **Sec. 907.** LEGISLATIVE DIRECTIVE. Sections 101 through 901 of this act shall constitute a new chapter in Title 70 RCW.

Passed the House March 19, 1991.
Passed the Senate April 18, 1991.
Approved by the Governor May 21, 1991.
Filed in Office of Secretary of State May 21, 1991.

UNIFORM LAWS ANNOTATED

Volume 9

PART I

Matrimonial, Family and Health Laws

With
Annotations From State and Federal Courts

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UNIFORM HEALTH-CARE INFORMATION ACT

Table of Jurisdictions Wherein Act Has Been Adopted

Jurisdiction	Laws	Effective Date	Statutory Citation
Montana	1987, c. 632		MCA 50-16-501 to 50-16-553.

Historical Note

The Uniform Health-Care Information Act was approved by the National Conference of Commissioners on Uniform State Laws in 1985.

PREFATORY NOTE

The critical role that confidentiality plays in the provision of health care has been recognized almost from the inception of the medical profession. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L.Rev. 255 (1984) (hereinafter cited as Gellman). It is well accepted that confidentiality is essential to a patient's trust in a health-care provider and to a patient's willingness to supply information candidly for his or her benefit.

However, over the last several decades, a number of fundamental developments have threatened the confidentiality of health-care information. The emergence of third-party payment plans; the use of health-care information for nonhealth-care purposes; the growing involvement of government agencies in virtually all aspects of health care; and the exponential increase in the use of computers and automated information systems for health-care record information have combined to put substantial pressure on traditional confidentiality protections. Privacy Protection Study Commission, *Personal Privacy in an Information Society*, 283 (1977) (hereinafter cited as Privacy Commission Report).

To make matters worse from a privacy standpoint, the sheer amount of personal data kept in health-care records, and the number of individuals who monitor those records have mushroomed over the same period. It goes without saying that much of the information in health-care records is highly personal and, if disclosed improperly, may cause emotional, psychological, and physical harm to the patient. The Privacy Commission (1975–1977) and the National Commission on the Confidentiality of Health Record (1976–1979) received several hundred complaints from patients describing harms they suffered as a result of the misuse of their health records. The Canadian "Krever Commission" (*Report of the Commission of Inquiry into the Confidentiality of Health Information* (1980)) documented several hundred instances of abuse of medical records.

For all of these reasons Congress, state legislatures, courts, and health professional organizations have struggled over the last 20 years to develop law and policy that restore patient privacy and confidentiality protections. Nevertheless, the great majority of states have not yet adopted comprehensive statutes that regulate the record-keeping practices of health-care providers.

In almost one-fifth of the states, comprehensive privacy acts—based more or less on the 1974 federal Privacy Act, 5 U.S.C. § 552(a)—provide some assurance that state-held medical records will not be disclosed to third parties without first obtaining the patient's consent. E.g., Ark.Stat.Ann. § 16-802 *et seq.*; Conn.Gen.Stat.Ann. § 4-190 *et seq.*; Ind.Code Ann. § 4-1-6-1; Mass. Gen.Laws ch. 30 § 63, ch. 66A §§ 1-3, ch. 214 § 3B; Minn.Stat.Ann. § 15.162

et seq.; Ohio Rev.Code Ann. 1347.01 *et seq.*; Utah Code Ann. § 63-50-1 *et seq.*; Va.Code § 2.1-377 *et seq.*

However, only two types of health-record legislation are common to virtually every state. First, statutes in every state require health-care providers to report certain types of patient information to state agencies. Typically, these statutes require providers to report health data concerning their patients who have: violent injuries (gunshot and knife wounds are most common); contagious or infectious diseases; tuberculosis; venereal disease; occupational illnesses or injuries; certain congenital defects; and injuries from child abuse.

Secondly, almost every state recognizes some type of provider-patient privilege. The privilege permits the patient to restrict his physician (and occasionally other types of health professionals) from disclosing in many types of judicial proceedings, information received in confidence from the patient about the patient's health. Because a physician-patient privilege did not exist at common law, courts do not recognize a privilege in state without statutory provisions. (South Carolina, Texas, and Vermont do not have health-care provider-patient privilege statutes and are thus the exception to the rule.)

Most privilege statutes expressly provide that the privilege belongs to the patient and thus can be waived by the patient. Other circumstances in which physicians can be compelled to provide information to a court include court-ordered examinations, where child abuse is at issue, where involuntary hospitalization is at issue, and where the patient relies upon his medical condition as a defense.

It is difficult to generalize about privilege case law since it involves statutory, common law, and occasionally constitutional doctrines. However, privilege decisions seem increasingly to narrow the circumstances under which privilege can be claimed, and to expand exceptions requiring providers to provide health-record information. This trend confirms the opinion of many health-care professionals that the privilege doctrine is an increasingly fragile shield to protect the confidentiality of the health-care relationship. Gellman, *supra*, p. 3, at 272.

Virtually all major health professional groups, including the American Medical Association, the American Hospital Association, the American Nurses' Association, the American Psychiatric Association, the American Medical Record Association, and the American Psychological Association, have adopted formal codes, guidelines, or policies regarding the handling of health records. For legislative audiences, the American Psychiatric Association, the American Medical Records Association, and the American Medical Association, among others, developed model health-record confidentiality statutes.

In drafting this Act, the Conference took into account the proposed standards and model statutes written by these health professional groups and national commissions. The Act embodies many of the standards and all of the principles found in the recommendations of the federal Privacy Protection Study Commission. Existing and proposed state and federal statutes were also reviewed and utilized.

Many of the organizations with a direct interest in the subject of this Act participated directly in the Conference's drafting process. These included the American Medical Association, the American Hospital Association, the American Medical Records Association, the American Psychiatric Association, the Health Insurance Association, the United States Department of Health and Human Services, the United States Department of Justice, and the American Bar Association. In addition, the Conference sought and received written input from numerous other interested organizations and individuals including the National Blood Bank Association, the Hospital Pharmacists Association,

the American Society of Internal Medicine, the American Society of Law and Medicine, and others. Although such assistance is gratefully acknowledged, the Conference is solely responsible for the final product which was the subject of three years of effort by the Drafting Committee and was debated by the entire Conference in two separate years.

The contents of Article I address more specifically the underlying reasons for the Act, as Legislative Findings.

UNIFORM HEALTH-CARE INFORMATION ACT

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FINDINGS AND DEFINITIONS

§ 1-101. Legislative Findings

The [Legislature] finds that:

(1) Health-care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy, health-care, or other interests.

(2) Patients need access to their own health-care information as a matter of fairness to enable them to make informed decisions about their health care and correct inaccurate or incomplete information about themselves.

(3) In order to retain the full trust and confidence of patients, health-care providers have an interest in assuring that health-care information is not improperly disclosed and in having clear and certain rules for the disclosure of health-care information.

(4) Persons other than health-care providers obtain, use, and disclose health-record information in many different contexts and for many different purposes. It is the public policy of this State that a patient's interest in the proper use and disclosure of the patient's health-care information survives even when the information is held by persons other than health-care providers.

(5) The movement of patients and their health-care information across state lines, access to and exchange of health-care information from automated data banks, and the emergence of multi-state health-care providers creates a compelling need for uniform law, rules, and procedures governing the use and disclosure of health-care information.

COMMENT

The inclusion of a statement of legislative findings is a common practice in privacy legislation. These findings aid agency officials, courts, and the public in identifying and properly applying the Act's purposes. The Conference's Uniform Information Practices Code contains a statement of "General Provisions" which sets forth the purposes to be served by the Information Practices Code.

The first statement recognizes the extraordinary sensitivity of health-care information. The second expresses the Act's view that patients should have access to their own health-care information and an opportunity to correct inaccurate or incomplete information. The Act seeks to give patients more control over their health-care information by giving them a right to see and copy their own records and to correct and amend their records when these records are in the hands of health-care providers.

The third statement expresses the view that health-care providers have an interest in assuring the confidentiality of health-care information and in being able to rely upon clear and certain rules to govern disclosure decisions. In this regard the Act permits patients to approve or disapprove disclosures by health-care providers to third parties in most instances. Moreover, the Act seeks to restrict and regulate the flow of health-care information to third parties by carefully limiting disclosures that can be made without patient consent; by restricting the acquisition of health-care information by compulsory process; and by imposing security requirements on health-care providers maintaining such data.

The fourth statement makes the point that many nonhealth-care providers obtain, use, and disclose health-care information for innumerable nonhealth-care purposes. It is the public policy of the state that a patient has an interest in the proper use and disclosure of the patient's health-care information even when the information is held by nonhealth-care providers. The purpose of this statement is to recognize that such rights exist as a matter of case law and other expressions of public policy and to assure that enactment of the Act—notwithstanding its general limitation to health-care providers—does not undercut health-record privacy rights that may exist under other law and in other contexts.

There are two reasons why the Act does not attempt to regulate the use or redisclosure of health-care information once such information is held by nonhealth-care providers (except in those limited circumstances set forth in Article II where a health-care provider makes health-care information available to third parties without the patient's consent and in order to meet the provider's needs or interests). First, the expectations that a patient and society can rightfully have concerning the use and disclosure of health-care information must necessarily change when health-care information is held by nonhealth-care providers. The type of relationship that nonhealth-care providers have with patients is inevitably different than the relationship that health-care providers have with patients. The interests that will be advanced or deterred by confidentiality are different; the needs of the nonhealth-care providers to use and disclose the information are different; and the threat to patient privacy interests is different. These issues are complex, and require different responses, depending on the identity of the particular holder of the record and the reasons for which the records are held.

Second, in recognition of these differing interests and needs Congress and state legislatures have already adopted, or are well along in the process of adopting, statutes that regulate the handling of personal information, including health-care information, when held outside of the health-care relationship. For example, the Fair Credit Reporting Act regulates the handling of health-care information by consumer reporting agencies. The Privacy Act of 1974 regulates the handling of health-care information by federal agencies. Over a dozen states have adopted statutes which regulate the handling of health-care information by state agencies.

A model privacy protection act, promulgated by the National Association of Insurance Commissioners, and thus far adopted in over ten states, addresses the handling of health-care information by insurance carriers. Several states have adopted statutes which regulate the handling of health-care information by private employers.

These legislative developments indicate as an empirical matter that a health-care information statute should not cover the handling of health-care information by nonhealth-care providers. As a conceptual matter a health-care information statute should not attempt to cover health-care information in other record-keeping settings because the expectations, interests, needs, and threats posed by the use and disclosure of health-care information in these different record-keeping relationships vary so significantly.

No doubt for these reasons, virtually every record-keeping and privacy statute that has been adopted, including the Conference's Uniform Information Practices Code, regulates personal information according to the type of record-keeper holding the information, and not according to the type of personal information being held. In taking this approach Congress, state legislatures, and other legislative authors are acting in a manner that is consistent with the recommendations of the Privacy Protection Study Commission.

Notwithstanding all this, the extraordinarily sensitive nature of health-care information makes it appropriate to provide, as statement four does, that it is the public policy of the state that a patient retains his privacy interest in health-care information even after the information leaves the provider-patient relationship.

The fifth and final statement in the Findings section explains that a uniform law is necessary due to the movement of patients and their health-care information across state lines; the use of automated information systems; and the emergence of multi-state health-care providers.

Certainly, it is increasingly common for patients to have health-care information created in one state but used in another state. Given the mobility of patients, and the patients' use of providers located in different states, it is important for patients to be able to rely on uniform rules for patient access and confidentiality. Moreover, health-care information is increasingly maintained and communicated via automated information systems. The effective operation of these systems and their operation in a manner protective of patient interest is advanced by uniform confidentiality standards.

Furthermore, health care increasingly is provided by many different types of providers. In the early part of this century roughly 85 percent of all health professionals were physicians. Today physicians make up only about five percent of the total. *Dilemma, A Report of the National Commission on the Confidentiality of Health Records* (1977), at p. 2. Thus, patients' physicians' ethical tradition of confidentiality plays a diminishing role in assuring health-record privacy.

Moreover, not only are health-care occupations changing, so too is the corporate status of health-care providers. Increasingly, health care is provided by national corporations with health-care operations in many different states. Some of these corporations have begun to centralize their record-keeping operations. As a result of these changes in the health-care industry, it is of growing importance that providers be able to rely upon uniform confidentiality standards.

§ 1–102. Definitions

As used in this [Act] unless the context otherwise requires:

(1) "Audit" means an assessment, evaluation, determination, or investigation of a health-care provider by a person not employed by or affiliated with the provider to determine compliance with:

(i) statutory, regulatory, fiscal, medical, or scientific standards;

(ii) a private or public program of payments to a health-care provider; or

(iii) requirements for licensing, accreditation, or certification.

(2) "Directory information" means information disclosing the presence and the general health condition of a particular patient who is an in-patient in a health-care facility or who is currently receiving emergency health care in a health-care facility.

(3) "General health condition" means the patient's health status described in terms of "critical," "poor," "fair," "good," "excellent," or terms denoting similar conditions.

(4) "Health care" means any care, service, or procedure provided by a health-care provider:

(i) to diagnose, treat, or maintain a patient's physical or mental condition, or

(ii) that affects the structure or any function of the human body.

(5) "Health-care facility" means a hospital, clinic, nursing home, laboratory, office, or similar place where a health-care provider provides health care to patients.

(6) "Health-care information" means any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and relates to the patient's health care. The term includes any record of disclosures of health-care information.

(7) "Health-care provider" means a person who is licensed, certified, or otherwise authorized by the law of this State to provide health care in the ordinary course of business or practice of a profession. The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices.

(8) "Institutional review board" means any board, committee, or other group formally designated by an institution, or authorized under federal or state law, to review, approve the initiation of, or conduct periodic review of research programs to assure the protection of the rights and welfare of human research subjects.

(9) "Maintain,"as related to health-care information, means to hold, possess, preserve, retain, store, or control that information.

(10) "Patient" means an individual who receives or has received health care. The term includes a deceased individual who has received health care.

(11) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

COMMENT

This section contains the Act's definitions.

Subsection (1) defines the term "audit." The definition of audit is important because the Act allows nonconsensual disclosure for the purpose of an "audit." See Section 2-104(10). Audit is defined broadly to include government and private assessments, evaluations, determinations, or investigations relating to compliance with statutory, regulatory, fiscal, medical, or scientific standards, or compliance with a private or public program of payments to health-care providers. Thus, audit may include traditional governmental auditing as well as private health program auditing, including rate setting and rate review.

Audits also include assessments and investigations for licensing, accreditation, or certification of health-care facilities or providers by such organizations as the Joint Commission on Accreditation of Hospitals.

Organizations, such as hospital management companies, Blue Cross/Blue Shield and commercial insurers, which evaluate utilization, financial, or management practices under contractual arrangements with health-care facilities or providers also are included in this definition. These organizations, however, may not use their audit authority to obtain information to make decisions about payment of a particular patient's claim. Insurers can obtain information for claim purposes only by first obtaining the patient's consent, pursuant to Section 2-102.

Subsection (2) defines "directory information" as the disclosure of the presence and general health condition of an in-patient in a health-care facility or one who is receiving emergency treatment in a health-care facility. Under the terms of Section 2-104(6), a health-care provider may disclose directory information without the patient's consent, unless the patient has instructed the health-care provider not to make the disclosure.

Disclosure of a patient's presence can include sufficient information to identify the patient and his location, including room and telephone numbers within the facility. While a facility is expected to exercise appropriate discretion to minimize the extent to which the disclosure of directory information jeopardizes patient privacy, disclosure of such information is generally proper absent instructions from the patient.

Subsection (3) defines "general health condition" to mean a generic description of the patient's health status such as "critical," "fair," "good," etc. The term "general health condition" does not include information about the diagnosis, symptomatology, or prognosis for the patient.

Subsection (4) defines "health care" broadly to include any type of service to diagnose, treat, or maintain a patient's physical or mental condition. The second part of the definition is included to make clear that medical procedures performed on one patient to help another, such as the withdrawal of blood by a bloodbank or a kidney transplant, are included.

Subsection (5) defines "health-care facility" to mean any physical location, such as a hospital, clinic, laboratory, or office which is maintained to permit a health-care provider to dispense health care.

Subsection (6) defines "health-care information" as any information in any form which relates to the patient's health care and can identify the patient. This definition is broad and includes all provider-maintained information, including a patient's personal health history, that both relates to health care and can be used to identify the patient. Health-care information does not include birth or death certificates or information which cannot be linked to a particular patient. Health-care information includes the record of disclosures of health-care information (the disclosure log). Providers are required to maintain such a log under Section 2-101(b) of the Act.

Subsection (7) defines "health-care provider" to mean any person licensed, certified, or otherwise authorized by state law to provide health care as a business or a

profession. The term "otherwise authorized" connotes some kind of formal recognition by appropriate authorities that the person is entitled to provide health care as a business or profession. Thus, family members providing health care are not covered, whereas licensed laboratories are covered.

However, this definition does not include pharmacists (except pharmacists that are employed by health-care providers, such as hospitals) or others who provide health care solely through the sale or dispensing of drugs or medical devices. Persons who dispense health care exclusively through the sale of drugs and medical devices—pharmacists primarily—are excluded because they traditionally have a different relationship with their patients than do health-care providers. The relationship more closely resembles a seller-customer relationship than a provider-patient relationship. In addition, pharmacists and drug companies have an information relationship that should not be disturbed in an Act designed to address problems in the provider-patient relationship.

Subsection (8) defines "institutional review board" (IRB) to mean any board, committee, or other group designated by an institution to protect the rights of human research subjects. The definition includes IRB's established under Section 474 of the Public Health Service Act or state law.

In the last few years, IRB's have become a familiar part of the medical landscape. Federal health-care facilities and most other medium to large health-care facilities have created IRB's to review requests for the conduct of human experimentation research. IRB's are used in this Act as the necessary approval mechanism for research projects which are authorized to obtain access, in the provider's discretion, to health-care information, without patient consent. If a particular facility does not have an IRB, it is expected that researchers will find an appropriate IRB. The Act authorizes providers to rely on a finding by any qualified IRB, even if that IRB is not affiliated with the provider.

Subsection (9) defines "maintain" broadly to mean any act of holding or controlling health-care information. A provider who maintains health-care information is subject to the requirements of the Act.

Subsection (10) defines "patient" to include both living and deceased individuals who receive or have received health care. The right of privacy survives death because reputation may be substantially harmed by the release of health-care information. When this occurs, family members and others may be harmed and so may the deceased's estate. The personal representative of the deceased, as set out in Section 6-102, has the right to exercise this surviving right of privacy. *See Boggess v. Aetna Life Insurance Co.*, 196 S.E.2d 172 (Ga.1973).

Subsection (11) defines "person" broadly to include any natural person or organizational entity, including trusts, partnerships, and corporations.

Action In Adopting Jurisdictions

Variations from Official Text:

Montana. Introductory material reads, "As used in this part, unless the context indicates otherwise, the following definitions apply:".

In par. (2), omits "currently" preceding "receiving emergency health care".

Par. (4) reads: "'Health care' means any care, service, or procedure provided by a health care provider, including medical or psychological diagnosis, treatment, evaluation, advice, or other services that affect the structure or any function of the human body."

Adds a paragraph which reads: "'Peer review' means an evaluation of health care services by a committee of a state or local professional organization of health care providers or a committee of medical staff of a licensed health care facility. The committee must be:

"(a) authorized by law to evaluate health care services; and

"(b) governed by written bylaws approved by the governing board of the health care facility or an organization of health care providers."

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